KINDRED HEALTH CARE, INC.
EDUCATION/TRAINING ATTENDANCE ROSTER

Program Title HIPAA – PRIVACY IN THE WORKPLACE **Date** _____

Facility Name _____ **Facility #** _____ **Course Material Attached?** **Yes** _____ **No** _____

Trainer /Facilitator Name _____ **Signature** _____

Signature of Trainer or Facilitator certifies that the following persons attended the training.

NAME	TITLE	SIGNATURE	LAST 4 DIGITS SSN
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

My signature indicates I attended the training program identified on this form.